Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/18/03.

## I. DISPUTE

Whether there should be reimbursement for CPT codes 20550 and 20550 –51 (x3) for date of service 8/21/03.

## II. RATIONALE

The service in dispute is denied as, "F – Fee guideline MAR reduction" and "JM – Accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid. Please refer to the applicable Medical Fee Guideline and/or Medicare Guideline for the correct code or modifier for the service rendered."

The Requestor states, in their letter dated, 12/31/03, "We feel these codes should be reimbursed in full because we billed exactly correct according to the new Medical Fee Guidelines. We feel that the insurance carrier's reason for non-payment of this service cannot be justified."

Carrier received the Notice of Medical Dispute on 12/19/03. There has been no response.

Commission Rule 134.202 (b), Medical Fee Guideline, effective 8/1/03, states that, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a services is provided with any additions or exceptions in this section." To determine the maximum allowable reimbursement (MAR) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: Rule 134.202 (c) (1) states, "For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology. The conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by Centers for Medicare and Medicaid Services multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

The CPT code (20550) and multiple procedure modifier (-51) were billed in accordance with the Medical Fee Guideline, effective 8/1/03. Per Medicare, the Multiple Procedure Rule will apply: first procedure paid at 100%; second, third, fourth procedure paid at 50%. Therefore, per Commission Rule 134.202, reimbursement is recommended.

Reimbursement methodology with multiple procedure rule:

First procedure (CPT 20550)
$56.71 (Medicare allowed amount) x 125% (conversion factor) = $70.89

Second procedure (CPT 20550 –51)
$56.71 (Medicare allowed amount) x 50% (multiple procedure) = $28.36 x 125% (conversion factor) = $35.45

Third procedure (CPT 20550 –51)
$56.71 (Medicare allowed amount) x 50% (multiple procedure) = $28.36 x 125% (conversion factor) = $35.45

Fourth procedure (CPT 20550 –51)
$56.71 (Medicare allowed amount) x 50% (multiple procedure) = $28.36 x 125% (conversion factor) = $35.45

Reimbursement recommended in the amount of $177.24.

## III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement in the amount of $177.24. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $177.24 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 26th day of March 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc